Responsible Party Information

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____
Street Apartment # City State Zip Code

Insurance Information

Primary Insured Persons Information:

Name: _____ Birth Date: _____ ID or SS#: _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Group#: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Phone Number: _____

Secondary Insured Persons Information:

Name: _____ Birth Date _____ ID# _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Group#: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name & Phone Number: _____

Consent for Services

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing **if** credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

IT IS OUR POLICY TO CHARGE $45.00 FOR MISSED APPOINTMENTS WITHOUT 48 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

X_____ **Date:** _____ **Relationship to Patient:** _____

Signature of Responsible Party / Parent or Guardian

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X_____

Signature of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Samuel Hayatt, D.M.D. Inc.:

X_____

Signature of Responsible Party/Parent or Guardian